SERFF Tracking Number:	*ALSB-127332527*	*State:*	*Arkansas*
Filing Company:	*Lincoln Benefit Life Company*	*State Tracking Number:*	*49384*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*FIC422 series*		
Project Name/Number:	*FIC422 series/FIC422 series*		

Filing at a Glance

Company: Lincoln Benefit Life Company

Product Name: FIC422 series	SERFF Tr Num: ALSB-127332527	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 49384
Sub-TOI: L08.000 Life - Other	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Devyn Stoltz	Disposition Date: 08/03/2011
	Date Submitted: 07/25/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: FIC422 series	Status of Filing in Domicile: Pending
Project Number: FIC422 series	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 08/03/2011
	State Status Changed: 08/03/2011
Deemer Date:	Created By: Devyn Stoltz
Submitted By: Devyn Stoltz	Corresponding Filing Tracking Number:

Filing Description:

We submit via SERFF the above-referenced forms for your attention and approval. These are new forms, not previously submitted, and they do not replace any currently approved forms.

Description of Forms

Application form FIC422 will be sent to policyholders along with a lapse letter. This letter indicates that the grace period of the policy has expired and the policy has lapsed. The policyholder is offered the opportunity to reinstate the policy by filling out the Application for Reinstatement and sending in the past due premium(s).

Explanation of Multiple Companies Listed on Form FIC422

Lincoln Benefit Life Company, Allstate Life Insurance Company (Allstate Life) and Surety Life Insurance Company will

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use the above referenced form. The reason these forms have been filed for use by three companies is to streamline our processes. We would like to have forms that can be used with each company's products.

Please be aware that no other company other than the ones listed at the time of filing, will be used on these forms. Should the need to add another company become necessary, the forms will be re-filed with your Department for approval.

These forms have been generated by our home office computer system. These forms may also be generated using other hardware, which can result in changes in formatting (e.g., typeface, margins, page breaks), but the contents will remain unaffected.

Please note that some of the variable information on the pdfs of these forms was bracketed using Adobe Acrobat. Although the bracketing appears on the attached pdfs when viewed electronically, the bracketing may not appear on printed hard copies unless your printer is given special instructions to do so.

Thank you for your consideration of this matter.

Sincerely,
Devyn Marie Stoltz
State Filing Project Manager
Contract Development and Filing

Company and Contact

Filing Contact Information

Devyn Stoltz,	dpors@allstate.com
3100 Sanders Rd, Suite M2A	847-402-9262 [Phone]
Northbrook, IL 60062	847-326-5224 [FAX]

Filing Company Information

Lincoln Benefit Life Company	CoCode: 65595	State of Domicile: Nebraska
2940 South 84th Street	Group Code: 8	Company Type:
Lincoln, NE 68506-4142	Group Name:	State ID Number:
(800) 525-2799 ext. [Phone]	FEIN Number: 47-0221457	

Filing Fees

SERFF Tracking Number:	*ALSB-127332527*	*State:*	*Arkansas*
Filing Company:	*Lincoln Benefit Life Company*	*State Tracking Number:*	*49384*
Company Tracking Number:			
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Product Name:	*FIC422 series*		
Project Name/Number:	*FIC422 series/FIC422 series*		

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	50.00 per form per company
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Lincoln Benefit Life Company	$50.00	07/25/2011	50040346

SERFF Tracking Number:	*ALSB-127332527*	*State:*	*Arkansas*
Filing Company:	*Lincoln Benefit Life Company*	*State Tracking Number:*	*49384*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*FIC422 series*		
Project Name/Number:	*FIC422 series/FIC422 series*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/03/2011	08/03/2011

SERFF Tracking Number:	*ALSB-127332527*	*State:*	*Arkansas*
Filing Company:	*Lincoln Benefit Life Company*	*State Tracking Number:*	*49384*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*FIC422 series*		
Project Name/Number:	*FIC422 series/FIC422 series*		

Disposition

Disposition Date: 08/03/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ALSB-127332527*	*State:*	*Arkansas*
Filing Company:	*Lincoln Benefit Life Company*	*State Tracking Number:*	*49384*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
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Project Name/Number:	*FIC422 series/FIC422 series*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Form	Reinstatment Application		Yes

SERFF Tracking Number:	*ALSB-127332527*	*State:*	*Arkansas*
Filing Company:	*Lincoln Benefit Life Company*	*State Tracking Number:*	*49384*
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*FIC422 series*		
Project Name/Number:	*FIC422 series/FIC422 series*		

Form Schedule

Lead Form Number: FIC422 series

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	FIC422	Application/ Enrollment Form	Reinstatment Application	Initial		60.000	FIC422 Life Reinstatement App (0711) PF bracketed.pdf

APPLICATION FOR REINSTATEMENT

☐ **Lincoln Benefit Life Company ["The Company"], Lincoln, NE 68501, FAX 1-800-525-9287**
☐ **Allstate Life Insurance Company ["The Company"], Northbrook, IL 60062, FAX 1-800-525-9287**
☐ **Surety Life Insurance Company, ["The Company"], Lincoln, NE 68501, FAX 1-800-525-9287**

Policy No. ☐☐☐☐☐☐☐☐☐☐ Primary Insured _____

I (each undersigned) request that the Company reinstate this policy. I declare that all answers written herein are full and correct to the best of my knowledge and belief. Coverage will not start again until this request is approved by the Company and all required premiums and interest are paid. I understand and agree that the contestability period will begin again from the date of approval. If this request is not approved, any amount tendered will be returned.

HEALTH AND MEDICAL HISTORY

Answer Questions 1 - 9 for all Proposed Insured(s) including children, and give details below.

1. In the past 10 years (or since becoming insured under this policy, if less) has any person insured or proposed for insurance under this policy been diagnosed with, or sought or received treatment or advice for:
   - a. high blood pressure, heart attack, stroke, or other disorder of heart or blood vessels? ☐ Yes ☐ No
   - b. cancer or tumor? ☐ Yes ☐ No
   - c. dependency on or addiction to alcohol or any drug? ☐ Yes ☐ No
   - d. diabetes? ☐ Yes ☐ No
   - e. epilepsy or seizures, disorder of the brain or nervous system, depression, or other mental or nervous disorder? ☐ Yes ☐ No
   - f. asthma, emphysema, sleep apnea, or any lung disorder? ☐ Yes ☐ No
   - g. any disorder of the digestive tract, liver or pancreas? ☐ Yes ☐ No
   - h. anemia or other disorder of blood or blood cells? ☐ Yes ☐ No
   - i. disorder of kidneys or reproductive organs? ☐ Yes ☐ No
   - j. arthritis or disorder of bones, skin or muscle? ☐ Yes ☐ No
2. Other than previously disclosed, in the past 5 years, have any Proposed Insureds:
   - a. had a checkup, consultation, hospitalization, illness, surgery, or medical or diagnostic test? ☐ Yes ☐ No
   - b. been advised to have a medical consultation, diagnostic test, or surgery that has not been done? ☐ Yes ☐ No
3. Are any Proposed Insureds taking any prescription medications not previously disclosed? ☐ Yes ☐ No
4. Have any Proposed Insureds had more than one moving violation in the past 3 years or been convicted of driving under the influence or reckless driving in the past 10 years? ☐ Yes ☐ No
5. In the past 3 years, have any Proposed Insureds:
   - a. flown as a pilot or crew member of any aircraft? (If "yes" submit applicable questionnaire) ☐ Yes ☐ No
   - b. engaged in sky or scuba diving, vehicle racing, mountain or rock climbing? (If "yes" submit applicable questionnaire) ☐ Yes ☐ No
6. Have all Proposed Insureds resided in the U.S. continuously for the last 3 years? ☐ Yes ☐ No
7. Do any Proposed Insureds plan to spend more than 2 weeks outside the U.S. in the next year? ☐ Yes ☐ No

PRIMARY PROPOSED INSURED

8a. Name, Address, and Phone of Primary Physician or Medical Facility (If none, state "None")

8b. Have you visited this physician/facility in the last 5 years for any reason not already explained? (If "yes", explain below) ☐ Yes ☐ No

8c. Height: _____ Feet _____ Inches

Weight: _____ Pounds

8d. Do you currently use tobacco or nicotine? ☐ Yes ☐ No

8e. If "yes" to 8d, what type: ☐ Cigarettes _____ per _____
☐ Cigars _____ per _____ ☐ Pipe
☐ Smokeless ☐ Nicotine gum/patch ☐ Other _____

8f. If "no" to 8d, have you ever used tobacco or nicotine? ☐ Yes ☐ No
If "yes", what did you use: ☐ Cigarettes ☐ Other _____
When did you quit (MM/YYYY)? _____

ADDITIONAL/JOINT INSURED

9a. Name, Address, and Phone of Primary Physician or Medical Facility (If none, state "None")

9b. Have you visited this physician/facility in the last 5 years for any reason not already explained? (If "yes", explain below) ☐ Yes ☐ No

9c. Height: _____ Feet _____ Inches

Weight: _____ Pounds

9d. Do you currently use tobacco or nicotine? ☐ Yes ☐ No

9e. If "yes" to 9d, what type: ☐ Cigarettes _____ per _____
☐ Cigars _____ per _____ ☐ Pipe
☐ Smokeless ☐ Nicotine gum/patch ☐ Other _____

9f. If "no" to 9d, have you ever used tobacco or nicotine? ☐ Yes ☐ No

If "yes", what did you use: ☐ Cigarettes ☐ Other _____

When did you quit (MM/YYYY)? _____

ADDITIONAL INFORMATION - Please list any details to Questions 1-9:

Question Number	Proposed Insured Name	Details (name of condition, dates, how treated, current status)	Name and Address of Doctor or Medical Facility

PERMIT TO OBTAIN AND DISCLOSE CERTAIN DATA

A. The Company, its reinsurers, consumer reporting agencies, and other parties acting on The Company's behalf may get data about my health, medical history, prescription medication history and related information, mode of living (except as may be related directly or indirectly to sexual orientation), avocations, finances, credit history, driving record, and any criminal record. I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or benefits, or for The Company to determine its obligations under the policy issued in connection with this application.

B. Any doctor, practitioner, medical or medically related facility, laboratory, Pharmacy Benefit Managers, the Veterans Administration, the Medical Information Bureau, Inc. (MIB, Inc.), viatical settlement company, employer, consumer reporting agency, creditor, government agency, insurance or reinsurance company or any other person or entity which has such data about me may give such data to The Company and its reinsurers when this Permit or a copy of it is shown. All sources but the MIB, Inc., may give such data to agents or agencies acting on behalf of The Company. The information as provided herein pursuant to the authorization will not be redisclosed unless authorized by me or otherwise required by law. Covered entities, as defined by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment, enrollment, or eligibility for benefits on whether this Permit is signed.

C. Any request by The Company for medical records is on my behalf; the information must be provided within any requirements imposed by applicable statutes governing patient access to medical records.

D. Data about mental illness, alcoholism, sexually transmitted diseases, and the use of drugs is to be included.

E. The Company or its reinsurers may make a brief report about me to the MIB, Inc.

F. This Permit is good for 24 months after it is signed. **I understand that, if applicable, my electronic signature on this form operates as my original signature.**

G. The Company may obtain an investigative consumer report ("inspection report") on me. ☐ I want to be interviewed if such a report is obtained.

H. I have read this Permit and know I may request a copy of it. I may revoke this Permit by writing to The Company. I also have received the Disclosures and Notices.

Substitute Form W-9 - Under penalties of perjury, I certify that:

1. **The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and**
2. **I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and**
3. **I am a U.S. person (including U.S. resident alien).**

The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

SIGN HERE

Signature of Owner, if other than Insured (and title, if applicable, such as "Trustee" or "President") — SSN/TIN

Owner's E-mail Address

Signature of Joint Owner (and title, if applicable, such as "Trustee" or "President") — SSN/TIN

Joint Owner's E-mail Address

Signature of Primary Proposed Insured — SSN/TIN

Primary Proposed Insured's E-mail Address

Signature of Additional/Joint Proposed Insured — SSN/TIN

Signature of Parent/Legal Guardian (if any Insured is under Age 15)

Parent/Legal Guardian's E-mail Address

Signed at (City, State) | Date (MM/DD/YYYY) | Signature of Agent

DISCLOSURES AND NOTICES - Please leave with Applicant

IMPORTANT INFORMATION REGARDING MEDICAL EXAMS

As part of the underwriting process we may ask for medical tests or exams to be completed at our expense. Common tests may include a paramedical exam, which will consist of questions about your medical history and measurements of your body including, but not limited to height, weight, blood pressure, and pulse. Blood and urine specimens are also generally collected. Undressing is not required for any of these tests. In some instances, an EKG (Electrocardiogram) may be required. An EKG is a recording of the electrical impulses in the heart. You will be asked to lay down with your shirt unbuttoned so the EKG leads can be placed on your chest.

If you have any questions about the specific tests that will be required of you, please feel free to contact your agent.

NOTICE REGARDING THE MIB

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

INSURANCE INFORMATION PRACTICES

We will rely primarily on the information you give us. We may also get information from other sources, such as doctors, or other medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to gather information and send us an investigative consumer report as explained in the Notice Under the Federal Fair Credit Reporting Act below. You may ask to be interviewed as part of the preparation of any such report.

In certain limited circumstances, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. You have the right to be told about and to see and copy items of personal information about you that appear in our files, including information contained in the investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

We will send you a more detailed explanation of our information practices if you send us a written request. You may send your request to Underwriting Department, Allstate Life Insurance Company/Lincoln Benefit Life Company/Surety Life Insurance Company, P.O. Box 660191, Dallas, TX 75266-0191.

NOTICE UNDER THE FAIR CREDIT REPORTING ACT

In compliance with the Federal Fair Credit Reporting Act, you are hereby notified that an investigative report may be made. This would be by personal interviews with neighbors, friends, associates, or other persons. This will concern the character, general reputation, personal characteristics, and mode of living (except as may be related to sexual orientation) of any person proposed for insurance. You may obtain additional information concerning the nature and scope of this investigation and a written summary of your rights under the Federal Fair Credit Reporting Act by contacting our Home Office. Our address is Allstate Life Insurance Company/Lincoln Benefit Life Company/Surety Life Insurance Company, P.O. Box 660191, Dallas, TX 75266-0191. Upon your written request, you will be informed whether or not an investigation was made by us. If so, you will receive the name and address of the consumer reporting agency involved. You may receive and inspect a copy of the Investigative Consumer Report by contacting the consumer reporting agency.

NON-SUFFICIENT FUNDS (NSF) FEE

This notice is to inform you of a fee The Company may charge in the event that a life insurance policy premium payment and/or loan payment is not honored by your financial institution due to NSF. In the event there is a NSF transaction, we may charge a NSF fee up to $25.00 (fee varies by state). If your policy is on bank draft, we may draft your account for the NSF fee. If your policy is on direct bill, we may send you a paper bill for the NSF fee.

The NSF fee is separate from your policy premium payments. All policy premium payments must be made within the required time period to keep your policy in force.

IMPORTANT INFORMATION

For Applicants in Arkansas, Maine, New Mexico, and Ohio: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For Applicants in Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For Applicants in District of Columbia and Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Applicants in Florida: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

For Applicants in Kentucky and Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For Applicants in Louisiana and Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Applicants in New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For Applicants in Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

SERFF Tracking Number:	*ALSB-127332527*	*State:*	*Arkansas*
Filing Company:	*Lincoln Benefit Life Company*	*State Tracking Number:*	*49384*
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TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*FIC422 series*		
Project Name/Number:	*FIC422 series/FIC422 series*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
FIC422 Flesch Certification.pdf

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: Not a policy filing.
Comments:

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability
Comments:
Attachment:
FIC422 SOV _0711_.pdf

CERTIFICATION OF READABILITY

I, Robert Transon, Vice President, Allstate Life Insurance Company, Lincoln Benefit Life Company, Surety Life Insurance Company, hereby certify that these forms achieve a Flesch reading score as listed below and were created using no less than 10 point font:

Form Number	Flesch Score
FIC422 series	60

Robert Transon

Digitally signed by Robert Transon
DN: cn=Robert Transon, c=US
Date: 2011.07.18 12:26:40 -05'00'

Robert Transon
Vice President

July 18, 2011
Date

Statement of Variability
Allstate Life Insurance Company, Lincoln Benefit Life Company and Surety Life Insurance Company

FIC422 series

Items in the above-referenced form(s) are bracketed to indicate variable information. Some items vary to reflect policy-specific information. For other items, this Statement of Variability defines a permissible range that may be used for newly-issued policies without the necessity of a re-filing, thereby allowing the company to promptly respond to changes, such as in the market, company experience, or the regulatory environment. Any decision to apply a new factor within the permitted range, will affect newly-issued policies only, and not in-force business. Further, any such changes will be administered in a uniform, non-discriminatory manner.

Page	Bracketed Items	Description of Variability
1	Company Address	Company address may vary over time and allow for flexibility with Company phone numbers which may be added and vary over time
3	Substitute W-9	This section may be modified to include new information as required by state or federal tax requirements.
4	Notice Regarding the MIB	To allow for flexibility for the address, telephone number and email address of the MIB.
4	Insurance Information Practices	To allow for flexibility for the address of the underwriting company.
4	Notice Under the Fair Credit Reporting Act	To allow for flexibility for the address of the underwriting company.
4	Non-Sufficient Funds (NSF) Fee	To allow for the flexibility to modify or remove this section in its entirety on a non-discriminatory basis. Also to allow for the modification of the fee dollar amount.
4	Fraud Warnings	To allow for flexibility to make changes to comply with applicable state fraud warning requirements.